Washington School for the Deaf

Total Immersion Sign Language Program

Registration form

Return completed registration form with full payment of $395 (WSD accepts PO's) to:
WSD-TISLP- 611 Grand Blvd, Vancouver, WA 98661
Registration Form Due by June 1, 2007 (1st Session) July 1, 2007 (2nd Session)

FIRST SESSION: [ ] June 26-July 2, 2007
SECOND SESSION: [ ] July 31-August 5, 2007

Name_____

Address_____

City, State, Zip_____

Phone Number_____TTY/V_____

Email (home)_____Email (work)_____

Please indicate roommate preference_____

_____

Please indicate any dietary or accommodation needs_____

_____

I am: [ ] Hearing [ ] Hard-of-Hearing [ ] Deaf

Gender: [ ] Male [ ] Female

T-shirt size: [ ] Small [ ] Medium [ ] Large [ ] X-Large [ ] 2X-Large [ ] 3X-Large

ASL Skills: [ ] None [ ] ASL 101 [ ] ASL 102 [ ] ASL 103

Since you will be sharing rooms with others, please be sensitive to allergies and limit use of perfumes.

**For Smokers: No smoking is permitted on WSD Campus. Smoking is permitted off campus but please be sensitive to the smell of smoke on your clothing.*

Cancellation/Refund Amounts
Full refund before June 1, 2007 (1st Session)
Full refund before July 1, 2007 (2nd Session)
$50 cancellation fee June 2-13 (1st),
$50 cancellation fee July 2-13 (2nd)
$145 cancellation fee June 14-20 (1st)
$145 cancellation fee July 14-20 (2nd)

For more information contact
Kay Pedisich @ 360-696-6525 x0417 or
kay.pedisich@wsd.wa.gov

Photo Agreement

I, _____, understand that photographs and/or videotapes may be taken during the course of the program. Pictures and/or videos may be used for future mailings and/or publication purposes.

I also understand the Washington School for the Deaf will not take responsibility for lost or stolen items. There will be no alcohol, drugs or smoking on campus. The participant is expected to follow campus rules, and can be withdrawn by a Security Patrol Officer or WSD staff without a refund.

_____ _____
Participant Signature Date

Medical Agreement
I agree to permit a paramedic to take me to the hospital if incapacitated. If I am able to provide consent and decline treatment, I do so at my own risk. If I provide consent I am financially responsible for all medical treatment.

_____ _____
Participant Signature Date

FOR OFFICE USE ONLY

Total Enclosed_____ **Receipt No.**_____